LEADING QUESTIONS

A discussion paper on the issues of Nurse Leadership

Anne Marie Rafferty

KING'S FUND CENTRE

LEADING QUESTIONS

A discussion paper on the issues of Nurse Leadership

Anne Marie Rafferty

Published by the King's Fund Centre
126 Albert Street
London
NW1 7NF

Tel: 071-267 6111

ISBN 1 85717 040 7

A CIP catalogue record for this book is available from the British Library

Distributed by Bournemouth English Book Centre (BEBC)
PO Box 1496
Poole
Dorset
BH12 3YD

The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

Printed by Eyre & Spottiswoode Ltd, London and Margate.
Cartoons by Kipper Williams.

CONTENTS ??

PREFACE

The King's Fund has a long tradition of supporting the development of nurses and nurse leaders, not least through its post-war training colleges for matrons and for ward sisters. More recently it has been approached by a number of senior nurses to see whether the Fund could help in the development of this generation's up and coming leaders. There was said to be a leadership crisis in nursing, but it was not clear to the Fund whether there actually is a shortage of nurse leaders or whether the current policy and managerial arrangements in the NHS do not allow for the participation of nurses at top levels. Neither was it clear what exactly is needed to develop nurse leaders. The Fund therefore commissioned Anne Marie Rafferty to undertake a study of these issues, listening particularly to the views of current nurse leaders as well as looking outside nursing, and at nursing outside the UK.

The result of the study is this discussion paper. Its purpose is to help those responsible within and outside nursing to understand better the current situation and it presents ideas of what might be done to improve matters. The findings have been shared with a range of nurses and others at meetings at the King's Fund Centre. Along with the comments that we now receive, the findings will help the Fund decide what it can do to help.

There is no doubt in our minds that sound but imaginative leadership in nursing is essential, not only to ensure that the nursing profession is able to respond to the challenges it faces, but also for the sake of the NHS and those it serves.

In addition to Anne Marie Rafferty I would like to thank Janet Snell for help in making this such an accessible document, Jane Salvage for her enthusiasm in getting the work started, and finally all those who took part in the study (listed on page 28) and in the subsequent discussion.

Barbara Stocking
Director
King's Fund Centre

ACKNOWLEDGEMENTS

I should like to thank the following for their generosity in sharing their expertise and hospitality with me. Brian Wilson, Consumer Affairs and Nursing Director, Gwent Health Authority; Jo Boufford, King's Fund College, London; Peter Smith, Philip Hodgson and Dr Valerie Hammond, Ashridge Management College, Berkhamsted; Rosemary Stewart, Templeton College, Oxford; Malcolm Ross, Chief Nurse, Oxfordshire Health Authority; Mary Fitzgerald, Senior Sister, John Radcliffe Hospital; Professor Claire Fagin, Dr Cynthia Scalzi, Dr Dorothy Delbueno, School of Nursing, University of Pennsylvania; Dr Sheldon-Rovin, Leonard Davies Institute of Health Economics, University of Pennsylvania; Dr Anne-Marie Fralic, management and research staff, Robert Wood Johnson University Hospital, New Brunswick; Dr Steve Shroeder, Polly Seitz and Dr Ruby Herne, Robert Wood Johnson Foundation, Princeton; Dr David De Vries, Dr Bob Dorn, Dr Ellen Van Velsor, Dr Amy Webb and research staff, Center for Creative Leadership, Greensboro, North Carolina; Bonnie Vole, Dr Anne-Marie Brooks, Dr Pat Hinton-Walker, Dr Elizabeth Walker, teaching and research staff, School of Nursing, University of Rochester; Doris Armstrong, Hartford Hospital, Conneticut.

THE LEADER

I wanna be the leader
I wanna be the leader
Can I be the leader?
Can I? I can?
Yippee, I'm the leader
OK, what shall we do?

Roger McGough (b.1937)

AIM OF THE DISCUSSION PAPER

This paper attempts to clarify the key issues surrounding the question of nursing leadership. Is the profession producing high calibre nurse leaders in sufficient numbers and if not, what steps can be taken to rectify that? What can be done today to nurture and develop the nurse leaders of tomorrow? Is leadership ability innate or can it be learned and if so what is the best way to teach and develop it? What can nursing learn from other organisations on the subject? These are some of the questions addressed in addition to the fundamental issue: what exactly is leadership? A working definition to be going on with might be 'leadership is the ability to identify a goal, come up with a strategy for achieving that goal and inspire your team to join you in putting that strategy into action'. Leaders set the tone and shape the culture in organisations. They demand high standards, they create a culture of pride, make people feel important and enable them to realise their potential[1].

To shed some light on the issue, a series of interviews was held with a number of prominent figures in the nursing world. The paper details some of the key findings from that interview study and also examines the broader issue of nurse leadership and looks at some of the constraints on would-be leaders. A final section suggests some practical strategies for developing nurse leadership. But first, to set the scene, the paper describes the general context of the current leadership debate in nursing.

Leadership and the NHS

The so-called leadership crisis in nursing is not a problem peculiar to the profession alone. Changes in the funding and administration of the public sector in general have challenged the traditional freedom and fiefdoms of all professional groups. There does, however, appear to be a question mark over nursing's ability to promote a leadership consciousness and culture. In the NHS many other groups are also struggling to devise strategies to help them respond positively to the changes wrought by what has been described as the 'modernisation of the NHS'[2]. But what lies behind the leadership debate in nursing? Is it simply that nursing is failing to muster an adequate supply of leaders? Or is it that the 'right' kind of leaders are not coming forward? To what extent is the leadership debate in nursing a response to the introduction of general management? Or does it reflect the historical under-achievement and under-investment in the whole area of predominantly female occupations?

The issue of leadership has tended to reach the top of the political agenda during times of change and economic anxiety. As early as 1953, the Government was seeking ways to effect economies in the NHS and it set up the Guillebaud committee, so-called after its Cambridge economist chairman, to enquire into the cost of the service[3]. Much to the chagrin of Treasury officials, the committee refuted accusations of extravagance in the NHS[4]. So some alternative means had to be found to cut costs and over the ensuing decade management came to be perceived as the key.

This eventually led to a series of major upheavals including, notably, the Salmon Committee recommendations in 1966, which meant the demise of matron, and Griffiths in 1983 which ushered in general management. Nursing came under close scrutiny by the policy-makers who were still intent on maintaining stringent financial restrictions by the use of industrial and commercial models of management.

The legacy of the Salmon structure and consensus management, for which it was well adapted, institutionalised the expectation that nurses should and would have a voice at the policy table. But Griffiths changed all that. His report led to the issue of leadership acquiring renewed prominence in discussions on the NHS[5]. Leadership was portrayed as essential to the management of the workforce in the increasingly complex environment in which the NHS subsisted. Rather than regarding health-care as a separate case, general management treated business and the NHS as sharing the same practical problems of structure, finance and quality control[6]. Mere administration was to give way to business management and a single leader in the form of a general manager was installed in each tier of the organisation. General management challenged the power bases of the professions but there was huge variation in local implementation of the Griffiths proposals. Some districts eliminated nurses from the management board. Others changed their arrangements very little[7]. In principle, great opportunities existed for nurses to compete for key positions of influence in the new order though in reality comparatively few nurses have been appointed to general management posts.

It is not clear whether this is because they have been deliberately excluded from such positions or whether they applied and were unsuccessful or simply did not compete for the posts. At any event, the reverberations from the Griffiths restructuring are still being felt and have left some nurses dismayed at the nursing policy and leadership vacuum engendered by general management[8].

KEY FINDINGS OF THE INTERVIEW STUDY

Leadership versus Management

During an interview study with current nurse leaders, it became clear that any distinction between the function of leadership and the function of management is fraught with difficulties. This perhaps reflects the artificiality of any absolute or natural separation of the two ideas[9].

Some interviewees saw the entire leadership debate as an opportunity for disenfranchised professionals to wrest power and control from general managers. Others perceived leadership as more intellectually creative than management, demoting the latter to the realms of the routine and mundane.

During the interviews, two key themes emerged: leadership as a constellation of attributes and qualities and leadership as a process of influence and managing change. The nature of this influence and the opportunities to exercise it would depend upon the situation, the task in hand and the characteristics and needs of the group in question. The leadership role was not necessarily fixed but movable. It could rotate according to need and demand. Neither of the two themes were mutually exclusive and some commentators offered definitions which combined both.

Leadership versus Facilitators

Two specific forms of leadership became evident – the visible and the less visible. High visibility areas included the rallying, charismatic kind of leadership – the sort of people who 'burned' for nursing.

Less visible were the good facilitators who enabled and created a process and an environment in which to exchange ideas, and promote innovation and talent. This too was perceived as an important function of leadership.

What makes a good leader?

Central to good nursing leadership was the creation of a shared vision about destination and about the kinds of service that might be offered. In the new order of health care, leaders were singled out as being good politicians; managers of people who knew how to deliver a service. They possessed a number of qualities. As one interviewee put it:

> *'They're always intelligent people, not necessarily academic people but they have that combination of conceptual ability, vision that is driven I think from an emotional font and some practical ability to achieve that vision.'*

A good leader would ensure the necessary systems were in place and the political levers pulled to make the vision a reality. There was a strong sense that what was needed were very

intelligent, very able, calculating people who could act as skilled negotiators in the top positions. Several of the interviewees identified their own leadership roots in their political values which fuelled a desire to bring about change.

As John Adair, first Professor of Leadership Studies at Surrey University, remarked, there is a close inter-relationship between change and leadership. Change, he claims, tends to highlight the need for change and leaders are the ones likely to want to bring about change, even where others do not see the need for it[10].

During the interviews a leader was also portrayed as someone who was also warm, personable and humane, someone who:

> *'inspires you and whom others will follow but who will trust you. They will trust in your integrity... Leaders care for the people they are leading/serving. Leaders try to strengthen and promote these people... They facilitate and help and encourage and praise'.*

Leadership was viewed as centering around empathy for other people. It was important that nurses felt there was someone 'up there' fighting for them. A good leader was also a leader for 'good', exemplifying such moral qualities as integrity and fairness, reflecting the values of the led.

Some leaders were represented as magnets for talent, though as a developer of others they must always be prepared to lose some of their most able people. Credibility was crucial, too, and this meant leaders had to have command of their field. One of the problems identified in some nurse managers was that they were perceived as lacking the requisite expertise and therefore credibility in the eyes of their peers.

Perspectives on Leadership

Those taking part in the interviews could be broadly divided into three categories:

- sceptics
- idealists
- pragmatists.

'Sceptics' considered the so-called crisis in leadership an invention of the 'powers that be' to stimulate compliance with changes being made in the service. The issue was not one of supply but motivation. The sceptics also mooted the idea that perhaps the 'wrong' kinds of leaders were emerging.

They felt that suggesting leadership was a 'problem' for nurses implied that it was somehow nurses' fault. Furthermore, focusing on the apparent 'failure' of nurse leadership detracted from the important attempts by nurses to excel in their field and to innovate. It merely reinforced victim-blaming. Doubt was also expressed over policy-makers' motives. Was the commitment to developing leadership for nurses genuine or just an exercise in political window-dressing? As one interviewee remarked:

'The emphasis all the time is on low-cost solutions, never about looking at nursing within the overall context of what it means in terms of investment... If you want self-confident assertive nurses, there is no problem in achieving that... but at the end of the day, that is the last thing that policymakers want.'

Another sceptic noted that the leadership issue was potentially a political construction which:

'provides a useful sort of political shuttlecock, a rallying cry... It's difficult to say whether nursing is more short of leaders than any other group. Perhaps there's great consciousness of the need for leadership at a time when nursing feels under threat...'

Meanwhile the idealists, unlike the sceptics, considered the current supply of leaders as a cause for concern, especially in the community where the focus of much formal care was increasingly likely to take place. They blamed historical under-investment in nurse education at all levels and questionable promotion and selection criteria in the past for bequeathing a legacy of neglect, currently expressed in the 'crisis management' approach to leadership.

For idealists, leaders set a moral example. They inspired trust, demonstrated integrity, always acted in good faith and not for personal gain alone.

'Leaders try to strengthen and promote their people... They facilitate, help and encourage and praise. I think the successful ones go out there and touch people...'

'They have an enthusiasm, a liveliness. They have a visionary feel... They're always looking ahead... They're really committed to delivering something in the area in which they're working and they stay with it. They have a lot of energy. They're prepared to get the balance between paying attention to the day-to-day tasks that need to be done while holding on to a future point... There's usually a group around them who is willing to learn from them, trust them and you can see that in a first-year staff nurse.'

For the idealists the culture of conformity in nursing had thwarted the launching of leaders who would be willing to challenge the status quo. The 'muted' nature of nursing in key policy-making areas was attributed in part to the 'gendered' and 'second-class' citizen status of the profession.

The task of leadership for idealists was to:

'rescue nursing from the problem of being an invisible but necessary service that just copes and does the background work while others make the political moves for it.... Leadership is a heart as well as a mind game. It's about valuing people and transforming nursing work into something visible...'

Finally the pragmatists inclined towards the view that you work with what you have. They believed in going with the flow whatever the government of the day, while at the same time wresting the maximum political advantage.

The pragmatists were the ones who seemed most at ease with the notion of leadership and perceived its development as a key part of their work. In some cases they have initiated strategies to spot talent and promoted leadership potential. They had often participated in programmes themselves. They enthused about the power-broking process and had embraced the Government's NHS reforms with gusto. Theirs was not a blind conformity with the new order.

But they saw it as presenting opportunities for gain. It was a challenge from which advantage could be seized.

For the pragmatists leadership was about:

> *'making people change and having a handle on delivery of services to people... It's about making things happen.... Saying: "ok the rules have changed, what are the new rules? How do I get a decent understanding of those rules and how do I go in and play and manipulate the new rules?".'*

> *'Power isn't about lovely neat hierarchies. Power and change aren't about complying. Power and change are about having the right kind of game plans to beat the system.'*

Current and future nurse leaders needed to be prepared to handle the complexity of the demands being made upon healthcare, both financial and political. They needed to understand the nature of power, not to fear it but to gain control of it. They needed to learn how to manipulate the media and public opinion, create support networks, pick up on feedback and take risks.

It was clear from the range of perceptions which the interviewees had of the leadership issue that it was in danger of becoming a 'catch-all' category for the political and status grievances of nurses, past and present. Leadership was construed as a 'problem' and a 'solution'. Given the complexity and diversity of views and expectations, the question is whether it is possible for consensus on development strategies to emerge? We shall return to this fundamental issue later.

LEADERSHIP THEORIES

Many researchers have attempted to define leadership, but few have succeeded in capturing its essence[11]. This failure may in part be attributed to the assumption that leadership can be reduced to a formula, whose variables interact with law-like precision and regularity. But leadership is too unpredictable for that – it's a complex multi-dimensional and dynamic phenomenon. Yet the search for the elusive Holy Grail of leadership success continues and each new synthesis promises 'the answer' is within our grasp[12].

Research into leadership seems to have been motivated by two key objectives; firstly to identify the characteristics of leaders as an aid to selection and recruitment, and secondly to explore the relationship between leadership and organisational effectiveness and performance.

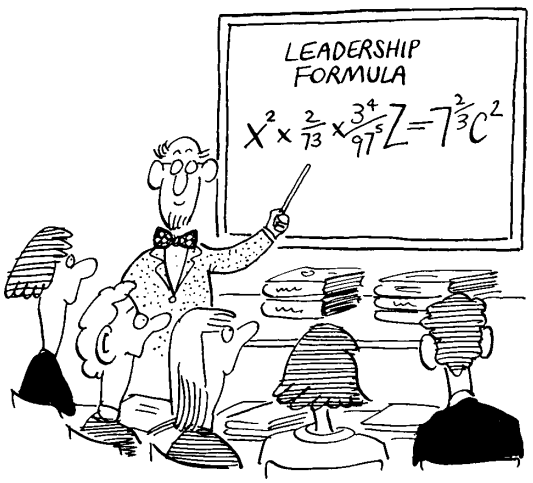
Theories of leadership vary according to the emphasis they place on:

- the personal characteristics of the leader;
- the effect of the leader on organisational functioning and culture;
- the leader's and group's behaviour.

The theories can be broadly divided into five categories:

- the constitutional
- the charismatic
- the circumstantial
- the contractual
- the constructivist.

The **constitutional** approach became popular around the turn of the century and maintained that leaders and leadership could be identified according to some universal criteria or 'traits' which distinguish leaders from non-leaders. According to this view, leaders emerge by virtue of their innate superiority – they are born rather than made and their superior talents explain their occupancy of leadership roles.



It could be argued however that this condones rather than challenges the status quo and assumes those who occupy positions of leadership always do so through merit. There is some correlation between

specific attributes predicting leadership success such as intelligence, extroversion and dominance, self-assertion and confidence, but success cannot be explained by those traits alone[13]. The theory also ignores or underestimates the extent to which access to leadership roles may be structured by social class, gender and racial inequalities. And it assigns a passive role to followers.

The **charismatic** or transformational approach is in some ways an extension of the constitutional approach since it focuses on the extraordinary and inspirational attributes of the leader. Transformational leaders heighten morale and motivation.

A 'vision' of a desirable future is invested with almost spiritual significance which appeals to the emotions and imagination of followers. It is this which provides the psycho-social cement which binds groups together in a commitment to the organisational 'mission'.

One criticism of this theory is that it is potentially exploitative. Leaders may capitalise on the conflict in the needs and value systems of followers. It also assumes a hierarchy of 'need' in which the emotional and the intellectual are considered separable from and superior to other forms of need.

According to the **circumstantial** view, leadership is more than a constellation of qualities, it is a role determined by the expectations of the group or organisation. Leaders help groups achieve their missions or tasks and hold those groups together as a socially cohesive whole by attending to individual needs. Effective leaders adapt their style: participative, autocratic, consultative, exploitative, benevolent, democratic, laissez-faire, for example – to the demand of the situation and followers' characteristics and needs.

One argument against this approach is that although it assumes followers may be active, it presupposes both leaders and led are working towards common goals.

The **contractual** or **transactional** approach proposes leadership is a process of reciprocal influence between leader and led. Leadership consists of a social exchange which is negotiated between both parties who bargain for mutual benefits as part of a reciprocal reward system. It assigns an active role to followers and provides scope for the possibility that leader and follower may be pursuing different goals.

However, it may be more conservative than creative and it tends to presuppose that human behaviour is pre-eminently motivated by reward and incentive systems.

Finally the **constructivist** approach conceives of leadership as the process whereby individuals succeed in defining the reality of others. Language is central to the success of social influence and leaders are skilled in the rhetoric of organisational culture and change. This reliance on rhetoric and the art of persuasion gives an advantage to those with highly developed language skills. But there is the potential for political manipulation.

Of course the context in which any research is conducted has important implications when considering how generally the findings can be applied. Much leadership research centring around the theories outlined above has been conducted either in the armed forces or management circles. How transferable such learning might be to nursing, whose work culture and gender composition differs significantly from those groups, needs to be considered when examining the leadership literature.

Having said that, these classic theories do tie in with the categories described earlier. Idealists and pragmatists seemed to subscribe to an eclectic model of leadership which combined one or more of the theories. On the other hand, sceptics appeared to be thoroughgoing purists. Idealists drew upon elements of charismatic and constructivist approaches. They believed in the exceptional individual's capacity to transform the thinking and behaviour of others, to turn cynicism, for example, into positive commitment. As the champions of the cultural autonomy of nursing they advocated the elaboration of a language of care to liberate nursing from its intellectual and social subordination to medicine and management. The target audience for the emancipatory philosophy of the idealist was the disaffected; those who would not normally be picked out by their line managers as capable since:

> *'they are normally 'bolshy', totally cheesed off with the whole system... they are the sort of critical mass of people that you need to have a conversion process... given the challenge and the possibility that they can change things'.*

Pragmatists' views blended the circumstantial and the contractual. Effective leaders adapted their style to the context and engaged in a process of bargaining for reciprocal rewards. Leadership consisted of mastering and manipulating the rules governing organisational rewards to mutual advantage. In some senses, the pragmatists behaved like organisational 'viruses': they adopted the guise of the host to infiltrate the hosts' domain and 'breed' success from within. Sceptics were constructivists. They believed reality was socially constructed and the task for nursing leaders was to expose the ideological basis of the leadership issue. Part of this task entailed alerting followers to the cynical motives and interests of the 'powers that be' in supporting leadership for nurses. Insofar as leadership consisted of defining the reality of others, nurses had to look critically at how the leadership itself was being constructed lest they be seduced into a 'false consciousness' or collusion or unwitting compliance with the new order.

CRISIS WHAT CRISIS?

'I think perhaps sometimes when people say we don't have enough leaders in nursing, they're saying we don't have enough people standing on platforms making rousing speeches.'

The interview study attempted to tackle the question of what exactly is the problem with nurse leadership. Is it an issue of quantity or quality or both? Or is the so-called crisis in nurse leadership more a media construction than a genuine problem? Some of the interviewees argued that nursing has failed to attract a sufficient proportion of high achievers due to its weak competitive position in the labour market. Perhaps nursing's image as facilitiative, caring and nurturing was not attracting ambitious high achievers. As one current leader commented:

'I can't say nursing feels to me like a world in which people are jostling for power and advancement ... and promotion is something that most people have their sights on ...'

Of course this begs the whole question of whether nursing really needs power-brokers, but certainly the introduction of general management and the 'commercialisation' of the health service was considered by the majority of interviewees as a cultural transformation inimical to many nurses' values. Some consequently shied away from striving to secure senior positions in the harsh, cut and thrust climate of the new order.

Value Systems

Nurses are likely to be attracted to the profession because of values antithetical to concepts such as competition. Central to the leadership debate lies the challenge of confronting conflicting loyalties between professional and managerial goals and the implications this has for determining the legitimacy of nursing leadership. But some current leaders expressed the view that nursing has to 'buy' into part of the new culture in order to set up a dialogue. But at the same time they must not lose their integrity or 'sell out' over basic principles.

At heart leaders must care both for and about people. One interviewee stressed the importance of becoming involved with groups of like-minded people because it furnished you with:

'the courage of your convictions, so that when you go into that next meeting with the high-powered general managers, even though you might feel you're on your own... you're also aware that you have those invisible supporters... if you're a representative of a culture that appears to clash with the dominant one you will be segregated or picked off or marginalised... but if you know that's their way of coping with you, you can refuse to be marginalised.'

Several people expressed the view that although general management had made an immense impact on nursing, nursing had apparently failed to make an impact on general management:

'The lip service that everyone gives... NHS Management Executive, politicians, the public... isn't parallelled by nurses actually 'getting in there' in the real sense and achieving important positions in sufficient numbers for it to be seen that nursing is a credible source of leadership.'

CONSTRAINTS ON WOULD-BE-LEADERS

The conclusion of most interviewees was that, whichever way one viewed leadership, there was no escaping the fact that there were simply too few nurses in high places in the NHS. This begs the question of what would amount to a satisfactory complement of leaders at the top? It could be argued that professions, by their very nature, have an insatiable appetite for talent.

But what exactly is it that's holding nurses back?

As stated earlier, perceptions of the status and severity of the so-called crisis in nurse leadership varied in current leaders' responses. Historical factors, institutionalised racism and gender politics were all invoked as key issues and we shall be looking at those. But a number of people expressed the view that nurses appeared to speak a different language and have a different value system from the dominant culture, a theory that is worth exploring further.

Language

Language was portrayed as a central issue since it was felt that many of the main elements of nursing were difficult to articulate and therefore somehow invisible. The 'invisibility' of nursing was compounded by its distance from the language of the dominant culture.

Among interviewees, the task of leadership was seen as 'rescuing' nursing from being viewed as an 'invisible but necessary' service. Nursing leadership is about:

> *'developing a language with which to describe and evaluate the less tangible features of care.'*

Nurses therefore had to learn the dominant culture's language and elaborate their expressiveness through research. Using the language metaphor, nurses would have to become bi-lingual at least. But as 'outsiders' they might never be regarded as truly part of the establishment. Conversely, they might become so well assimilated that they lost the sense of identity with their own indigenous culture, again highlighting the danger of selling out. What seemed to be implied was a fear of cultural imperialism. Some nurses felt their culture was being colonised and devalued by the new general management 'settlers' in the NHS. These people not only spoke a different language but also held a different set of values to the clinical 'tribes'. There was no guarantee that the 'colonisers' would hold the indigenous culture of nurses in as high esteem as their own. Nurses were under pressure to prove their worth and the value of their culture.

There was also a strong feeling that while nurses had to learn the new language, at the same time, the 'language of nursing' had to be introduced into the dominant culture if mutual understanding was to be promoted. But this argument assumes that the profession speaks with one, rather than many, tongues. Given the stratification within nursing, the language issue becomes even more complex, not solely concerned with vocabulary but also with 'accent' and 'dialect' too. The whole language metaphor can be seen as highly relevant to the wider struggle of nurses for cultural and intellectual autonomy.

Sexism

Hardy's pioneering work looking at the career histories of leading female and male nurses highlighted their different perceptions and experiences[14] . Female nurses in the study tended to be more highly qualified than men but took longer to reach the top. They followed a tortuous career path and realised relatively late in their careers that they had leadership potential. Davies and Rosser's study of career development opportunities in the NHS revealed a similarly 'gendered' pattern of job and promotion policies[15].

They argued that the operation of a 'male career path' in the NHS accounted for the structural inequalities and sexual discrimination in the NHS workforce. Consequently the preponderance of men at the top in nursing was out of all proportion to their numbers in the workforce. As with primary school teaching and social work, it seemed nursing leadership would become increasingly male-dominated[16]. Davies and Rosser concluded that there was little consideration of the working patterns of women's lives. In particular, job criteria operated against those who took career breaks and could not move around the country easily. Women with children were perceived as a 'problem'. The effect of such a policy systematically disadvantaged those who did not confirm to the male model. Women were unable to compete with men on an equal basis for leadership positions to which they both aspired. The authors concluded that it was:

> *'not choice but channelling which is the key feature of women's position, even though that channelling may not operate in any conscious or deliberate way'*[17].

Racism

Nursing has provided the focus for a number of studies on this issue. The disproportionate number of black nurses in lower grade posts, less popular specialisms and shift patterns has been documented by several commentators[18]. Limited access to rewards and promotion prospects has been attributed to discriminatory recruitment and employment policies. Such concerns led the King's Fund in 1986 to set up a task force on race discrimination in the NHS. There is little evidence of implementation of the task force's recommendations.

There are still very few nurses from black populations in leadership positions[19]. This too was perceived as an important issue in leadership development.

Equal Opportunities Employment Policies

Equal opportunities employment policies have a direct bearing upon leadership training and development. A report by the Equal Opportunities Commission on Women's Employment in the NHS has applauded new initiatives among health authorities to tap talent and train staff identified as having potential for leadership and performing at a senior management level[20]. Yet there was a caveat added that although such developments were to be welcomed, caution had to be exercised in ensuring that the initiatives did not reinforce traditional stereotypes of the ideal manager. For instance, Merseyside Regional Health Authority's scheme to identify 'high potential' nurses with leadership skills had selected 17 staff for 'fast tracking', 60 per cent of whom were male[21].

OPPORTUNITY 2000

In September 1991, the Department of Health was the first government department to become a member of the Opportunity 2000 campaign which aims to increase the quality and quantity of women's participation in the workforce by the year 2000[22].

The tone of the campaign document is very much that of an action plan. Specific goals in terms of quotas and target areas to be met by health authorities, family health service authorities and trusts are set out in the document. The objectives are two-fold: some aim to increase the numbers of women occupying senior positions, while others are designed to remove the barriers preventing women from competing for such positions.

Those devoted to improving women's occupancy of senior positions are confined to medical and 'business-related' spheres such as general management and accountancy. Medicine is the only 'professional' area targeted for increased participation of women in top clinical grades. For nurses and midwives, it would seem all roads lead to management, although it is not clear how such posts will be classified or differentiated from the clinical, and what place clinical leadership is expected to play in the career structures which Opportunity 2000 is intended to foster. Further guidance on the style, skills and knowledge for leaders in the NHS from 1995 onwards is promised[23].

Men and women in nursing are to be monitored for their career trajectories into management and opportunities provided for skills to be audited through a development centre.

In principle, the establishment of these diagnostic centres is to be welcomed but it is not clear what kind of service the centre will offer, how accessible it might be and the kinds of skills it will help promote and hone.

Positive action is recommended to help remove the barriers which prevent under-represented groups from securing better access to employment, promotion and training[24]. This is to be achieved by helping women position themselves so that they are more able to compete. Potential candidates will be monitored for their capacity to benefit from positive action[25]. A number of specific recommendations are consistent with present 'good' practice and other research which seeks to promote leadership in organisations. These include the creation and provision of: national networks, women-only management courses, executive coaching, work shadowing, identification of career sponsors and mentors[26]. The means and mechanisms by which such facilities and opportunities might best be provided is given little attention in the document. Solutions are proposed without due consideration to the character or 'causes' of problems or the rationale underpinning quotas and targets. The glib assumption that the problems of black and minority ethnic employees will be remedied by addressing the 'woman' question is also questionable.

Overall it could be argued that although the changes which Opportunity 2000 could engender should not be underestimated, the vision of equality is rather a narrow one. Furthermore, the emphasis on management may limit the scope for developing creative careers in nursing and other occupations concerned with the delivery of clinical services. Paradoxically, this may stymie rather than stimulate innovation. It remains to be seen to what extent such changes redistribute the resources and educational opportunities for leadership posts in the NHS in a manner which is sensitive to the politics of women's career patterns and aspirations[27]. The

Government's record on equality has arguably addressed a limited range of issues and many feminists remain ambivalent about their expectations of the State. Some might argue that women's own actions have had as much effect on certain aspects of equality as legislative measures[28]. Leaving the development of nursing leadership to the Government is a contradiction. Part of the leadership task for nursing must surely be setting the direction, pace and parameters for change within health care itself.

CAN LEADERSHIP BE LEARNED?

There is a school of thought which argues that leadership ability is innate and cannot be learned. Leaders will 'emerge' of their own accord and those who want to encourage them should concentrate on creating a conducive environment and then let them get on with it.

But a number of the interviewees felt strongly that they had in fact 'learned leadership' and that knowledge had come through political apprenticeships which sharpened up their skills in organising and campaigning as well as rhetorical skills. Others, particularly the idealists mentioned earlier, felt that prospects for leadership were enhanced with expanding access to higher education and that part of the reason nurses tended not to think of themselves as leaders was because in the past they had been excluded from the sort of institutions where leaders have traditionally been groomed. They have never been encouraged to see themselves as natural leaders in the same way as perhaps young people at Eton, Winchester, Sandhurst or Oxbridge have done. More than 100 years of nurse training has socialised nurses into loyalty compliance and respect for authority, both medical and managerial, a state of affairs that will hopefully be challenged by the latest United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) education reforms, particularly Project 2000, PREP (Post-Registration Education and Practice) and the development of academic nursing.

One of the UKCC's declared aims behind the Project 2000 reform of nurse education was to provide:

> *'a greater degree of professional unity and constructive participation in health policy'*[29].

Improving standards of training should help to boost leadership qualities in those coming up through the system, though there is unlikely to be any visible impact until at least five years after the first Project 2000 nurses quality.

With the UKCC's Post Registration Education and Practice proposals, the ideal of the advanced practitioner and the consultant nurse hold out some hope of providing a model that could be used to develop clinical leaders. This is important when so much of the emphasis seems to be on the development of managers as leaders.

Undergraduate programmes in nursing have been conducted in the UK since the 1950s. The expansion of nursing departments has been matched by developments in nursing research. Criticism is the life-force which drives the growth of knowledge, the mainstay of innovation and research. Elaborating the knowledge base of any practice discipline is expensive. However, research into nursing has attracted minimal investment compared with medicine. A more competitive funding market could depress investment in nursing research further. Some protected funding of nursing research may be necessary to preserve the gains of past investment. This needs to be combined with support for expanding the economic and intellectual frontiers of research by nurses. The profession must respond with vigour if it is seize the research agenda of the leadership challenge with confidence.

Can potential leaders be identified?

'Command of their field' was identified as a pre-requisite for leadership by some current leaders. Adair argues there are three main forms of authority in human affairs: the authority of position, personality and knowledge[30]. But technical competence and experience, although necessary, may not be sufficient qualification for leadership. If a leader in one field switches to another, the acquisition of technical expertise will be required but inter-personal and political skills are more likely to have organisational 'fit' and be transferable. Leaders who give direction, set an example and share danger and risk on an equal footing, win the voluntary support of others[31]. Adair uses a 'human needs' approach to leadership, arguing that leaders perform certain leadership functions. These include achieving the common task, maintaining the team and meeting the needs of individuals within the team. Adair suggests that if the common task has sufficient value for people concerned, groups and organisations will look for a leader who will help them accomplish that task[32]. According to this view, the need for leadership flows from the needs of the task and group dynamics.

Leaders may appeal to followers on a number of levels of needs fulfilment: the spiritual, intellectual, the moral and material. Change in any of these variables will generate new leadership functions and needs within organisations. This also suggests organisations themselves need to grow their own leaders.

Adair maintains the path to leadership is open to all, but this is somewhat contradicted by the fact that not everyone wishes to or has the ability or confidence to lead[33].

Leadership can be learned however, through experience, experimentation, reflection and reading[34]. Communication and listening skills, the 'personal touch' and the capacity to transmit ones inner thoughts and feelings are also important to the leadership task[35]. Role models, mentors and teachers are also regarded as important.

The interviewees believed that leadership qualities emerged very early on – in student nurses and certainly among young staff nurses. Those who went on to be leaders had initially been noticed because of their enthusiasm, their liveliness and their visionary qualities. In nearly all cases they were said to have been good communicators, persuasive and non-judgemental. Several current leaders said they had been spotted by 'look-outs' who identified and then nurtured their talent. Others felt they had risen to the top more by accident than design which prompted them to call for mechanisms built in to the system to ensure that potential leaders were spotted and not allowed to slip through the net. There was a strong feeling that leaders needed to be targeted and developed in a much more purposeful way. This reinforces the findings from Hardy's research on the career histories of nurse leaders in the early 1980s[36].

Mentoring in the classic sense is based on a relationship which at best involves an intense, mutually beneficial relationship between someone who is older, wiser, more experienced and powerful with someone younger or less experienced. It is a complimentary relationship within an organisation, based on mutual need. The word mentor originated in Homer's Odyssey. Mentor was a close friend of Odysseus who looked after his son Telemachus, while Odysseus travelled disguised as the goddess Athena, Mentor assumed male and female identities. Jeruchim and Shapiro argue this androgyny should be carried over into mentor-protégés relationships[37]. The ideal mentor, they maintain, should be nurturing, supportive, and protective as well as aggressive, risk-taking and assertive. Mentors may occupy a number of roles for protégés: teacher, friend, guide, protector and coach.

Women's position in the labour market and complex developmental pathways means that the conventional male mentoring model may not be appropriate. There may be limited availability of mentors for women due to the smaller numbers of women in the power structures from which mentors are traditionally drawn. Women may need more than one mentor: primary, secondary and symbolic female or peer mentors, to identify with male mentors yet keep their female identity intact[38]. This may depend upon the composition and character of the individual occupation and the availability of role models. What seems to be important in mentorship however, is not necessarily the gender of the mentor but his or her position in the power structure[39].

Jeruchim and Shapiro have defined a hierarchy of relationships which culminate in mentorship which advance from peer, coach, sponsor and mentor and varies according to the degree of intimacy and power involved in the relationship[40]. Peers are colleagues at work who can provide a strong network of support, a sounding board and political information about the organisation. They may serve as mentors if they possess expertise the protégée lacks.

Coaches become involved in the day-to-day feedback and appraisal, helping the protégée improve performance and prepare for advancement. Sponsors generally have more power in the organisation, which they use publicly to promote their protégée by putting forward the name of an individual for membership of a committee, for example, or making positive comments about an individual in a public forum[41]. Sponsorship may also benefit the sponsor by promoting the protégée's advancement. Not all sponsors become mentors but sponsorship is clearly an important part of mentoring.

What a number of interviewees described as mentorship could well be described as sponsorship. A number cited instances where they had been introduced to the informal power structures, put on committees, and been lobbied for, to join particular assignments. Much more research is required to identify and tease out the details and dynamics of the mentorship relationship in nursing. If mentorship models do not at present take into account the complex career pathways which women follow, new models need to be built and developed. Jeruchim and Shapiro provide an inventory of steps to help women locate and recruit a mentor[42].

Barriers to learning leadership

The historic under-investment in higher education for nurses has bequeathed a legacy of under-achievement and under-development in nursing. This may provide one reason why few nurses have not made it to the top in anything like the numbers one might expect, given their numerical strength in the NHS workforce. Another might be that there has never been any concerted or coherent attempt to harness the talent that nurses bring with them or develop on-the-job. Davies and Rosser's contention that the NHS provides an organisational climate which is hostile to women is also relevant here[43]. By this is meant that work is organised in ways which make it difficult for women and encourages the view that it is women who are problematic rather than the 'system' or organisation. However, it would be misleading to consider this a problem unique to nurses. It applies to other occupations in which women predominate and to groups such as ethnic minorities.

Researchers investigating the under-representation of women in executive ranks have offered a number of explanations. The first is that sexual stereotyping has prevented women from being perceived as potential leaders and therefore led them to being neglected in the promotion stakes. Secondly, organisations may focus on attracting rather than developing executive talent. When combined with gender stereotyping this may produce an environment in which women have less opportunity for development on the job[44]. A third explanation is that there are differences in how men and women learn from experience. Thus even when given the opportunity to develop, women do so in ways other than those expected[45].

In theory at least, it would seem there should be no shortage of opportunities for nurses to 'learn leadership'. McCall et al argue that most development takes place on-the-job[46]. However, the question mark over the degree to which leaders are born remains. Kotter concluded in his study of the background experiences of general managers that their mutual experience could be reduced to sharing a sense of optimism, emotional stability, and desire for achievement and power[47]. Successful executives are taught by demanding assignments, good or bad bosses, mistakes, setbacks and misfortune[48]. McCall et al's research challenges many of the development strategies used by organisations: mentoring, career-planning programmes and job rotations, claiming they are only of limited value in cultivating managerial talent. Adding to the scope of a job is only one of several developmental options; job rotation for the sake of it can waste resources and cross boundary movement is justified only when business plans call for certain new skills or specific challenges[49]. Job challenge seems to be important[50]. On-the-job development however does seem to be the virgin territory for the leadership researchers[51].

Little is known about what experiences or events are important in management careers. Training experiences in McCall's study depended on timing.

Classroom learning was important in conferring confidence but mentoring in terms of long-term apprentice/teacher relationships was rare. What seemed to matter was exposure to a variety of bosses, good and bad who possessed some kind of exceptional qualities[52]. Where executives said they gained insight into their strengths and weaknesses, this was not necessarily from counselling sessions but from their mistakes and confrontations with difficult subordinates, traumatic events and career setbacks[53].

Nursing has only begun to develop a leadership culture and consciousness[54]. Part of the present challenge for nursing and the NHS therefore must be to create a culture and a climate in which different models of leadership can flourish. How can and should this be achieved? Even if it

were agreed which models of leadership should be promoted, who should decide upon the means and ends of training programmes, how should programmes be designed and delivered? What skills need to be developed? What values might underpin programme development?

Systematic evaluations of leadership programmes are scarce. Adair's course for university staff is one of the few to have been assessed[55]. However, Adair's action-orientated programme is elusive on content and gives little insight into programme design or rationale[56] .

Of the 54 leadership training organisations operating in the UK in late 1991, only six provide some form of routine evaluation or post-course follow-up for members[57]. Leadership courses contain a large range of subjects and opportunities to develop skills through activities, feedback and reflection. These include; analysing one's own personal leadership style, creative problem-solving, learning styles, team roles and team leadership, project work, outdoor activities, inter-personal skills workshops, strategic leadership, negotiating skills, budgeting and accountancy systems[58].

It is likely that different kinds of leadership courses, learning and feedback opportunities for nurses are needed at different levels. Health authorities could be encouraged to sponsor a diagnostic survey of the need for leadership development in nursing at different levels within their organisation. However, responsibility for specifying, undertaking and co-ordinating such activities at local and national level needs defining. In order to balance local with national needs, and share ideas, experience and expertise, a combination of national and local workshops, opportunities and meetings are probably required.

Industry, commerce and health care are not, however, in business primarily to develop people, so development is likely to remain a secondary goal[59].

The accumulated evidence suggests women and men have different expectations and frames of reference[60]. Yet the literature on executive performance of women suggests that the psychological profiles of successful women are closer to those of their male counterparts than women in general[61].

The implications of such evidence are that in order to succeed, women must learn to play the male game by the male rules. They must identify with male values, deny 'difference' and work towards assimilation. Such an argument however, merely rehearses rather than re-works the dilemma facing women at work. Why should women deny and, by implication, denigrate 'difference', if this exists, (which some contest) especially when the nature and scope of opportunities for development do not appear to be equally distributed for men and women within organisations? If 'differences' between male and female executives are in fact more 'mythical' than 'real', perhaps it is the expectations of the organisational stakeholders which need to be re-educated and revised.

McCall et al found that most developmental experiences reported by men fell into three categories: 'assignments', 'hardships' and 'other people'[62]. Assignments consisted of those experiences deliberately allocated to people on the job, which encompassed a critical project or task force, an increase in job scope, being responsible for turning around an ailing part of the business or starting up a new part of the business. 'Hardships' consisted of the difficult, traumatic experiences which one encounters, on and off-the-job. These embraced career changes, personal traumas of self, family and business failures. 'Other people' experiences included observing others, often bosses, whether good, incompetent, difficult or helpful. Interestingly peer learning did not seem to feature in the study analysis.

Van Velsor and Hughes replicated the study with women. They found that women's opportunities for learning from a range of assignments was qualitiatively and quantitatively different from men's.

Women identified 43 per cent of all their learning as being derived from assignments, compared with men's reported 60 per cent. Furthermore, women reported fewer business turnarounds and no start-up-from-scratch assignments. The nature and scope of womens' assignments was more limited than that of men and their assignment progression much less orderly[63]. This is important when one considers diversity of experience may be essential to the development of expertise and cognitive complexity[64]. Women reported a similar level of 'hardship' including career setbacks, changing jobs, personal trauma and employee performance problems. But in one respect they differed and that was in the number of reported 'business mistakes' (any event which the manager considered a failure, project failure, failure to influence others or conflict with peers and superiors). Van Velsor and Hughes suggest that error may increase with task complexity in those with a narrower experience base[65]. What was particularly striking about women's performance was that their capacity to learn from other people was significantly higher than that reported by men. It is not possible to conclude from the study whether men focus their learning on specific tasks while women focus on people. However, the experiences made available to men and women seemed to differ. Whether this was an artefact of the research design or analysis, or a compensatory reaction by women to their lack of opportunity to learn from certain experiences is also not clear[66]. The magnitude of the difference, however, suggested that it was more than methodological artefact which was at work.

Whatever conclusions one may draw from such evidence, it seems much more needs to be accomplished in providing equal development opportunities for men and women in organisations. Moreover, women's 'difference' needs to be researched, identified and valued for the contribution it can make to organisational diversity. This needs to be acted on in a way which takes account of women's prior experience and history. Offering women challenges at work must also be combined with support. That support needs to be sensitive to the stress and pressure which 'high visibility' women face when breaking through the so-called 'glass ceiling'[67].

LESSONS FROM AMERICA?

As stated earlier, the conventional response of governments and reformers to rising expenditure in health has been to attempt to extract increased efficiency from existing resources. In the USA, as in the UK, failure to regulate costs by direct means has led government and sponsors of health care to divert attention towards providers as a source of financial discipline and restraint. Perceptions of leadership in the USA and UK reflect the differing cultures of health care as well as the social aspirations of nurse leaders themselves.

Much of the discussion on leadership in the USA has assumed the hospital as the focal point for cost-containment.

The historic 'extravagance' of the hospital sector has meant that the motives for developing leadership in nursing have tended to be driven by the management of economic trajectories in hospital care. Leadership in American nursing has tended to centre on the nurse executive role and a number of educational programmes have evolved to develop such a role. Some of these are degree programmes and others short intensive courses[68]. A number of the most recent developments have combined Masters of Nursing Programmes with Masters of Business Administration programmes and there are even some moves to provide a combined Ph.D/MBA.

In 1991, some sixteen universities were offering MSN/MBA programmes[69]. Increasingly a business qualification is considered necessary for nurses to gain credibility at the negotiating table with other health care executives. The nurse executive has been characterised as a 'hybrid' – a blend of a nurse and business person[70]. In a recent survey of chief executive and senior nurse executives' opinion on education preparation of top level nurses, the dual MSN/MBA degree was identified as the most popular choice of degree preparation for senior executive roles[71]. The importance of business skills and management experience integrated into the educational experience was also emphasised.

Such findings reinforce the attempts by nursing schools to establish close links with graduate business schools. The acquisition of business skills such as cost accounting, trend and variance analysis, personnel management, strategic planning, policy development and systems analysis, are suggested as being best developed in business schools[72]. Scalzi and Wilson have suggested that financial statement analysis, ratio analysis, debt financing, working capital management budgeting and budget variance analysis should be included in graduate education for nurses[73]. A recent USA study reveals that

most chief nurse executives, however, derive their knowledge of financial management through apprenticeship, and that this limits their potential contribution to devising creative resource-allocation solutions in times of fiscal crisis and rapid change[74].

Literacy and Legitimacy

However, there are fears that in the rush to become 'business-like and literate' nursing concerns may be overshadowed if not lost. The MSN component in the dual degree experience is intended to provide the balance necessary in bridging the gap between the practising nurse's perspective and goals and the organisation of health care more generally. It is felt that in this way, nursing objectives can more easily be incorporated within organisational goals.

Short courses, however independent of efforts to strengthen the business component of MSN degrees, are not the only solution to attracting talented students into nurse executive roles.

A number of intensive short courses have been developed to provide 'continuing education' for potential high flying nurse executives.

On the east coast, the Johnson and Johnson-Wharton Fellows Program in Management for Nurses is probably the most prestigious. The program consists of a three-week schedule designed to enhance the business management skills of nurse executives occupying the highest levels of responsibility in the hospital organisation. The emphasis of the course is on the executive functions of the nurse and elements include:

Advanced technology
Cost benefit analysis
Decision analysis
Financial management
Health economics
Managing change
Marketing
Negotiation
Organisation design and behaviour
People Management
Planning[75].

Clinical leadership

Leadership has also been perceived in the States as a solution to nursing's acute workforce problems of the recent past. The Commission on Nursing in the USA (1988)[76] was the latest to investigate the shortage of nurses. It recommended an increase in nurse participation in governance and management of organisations, developing collaborative relationships among health care providers, promoting positive and accurate images of the nurse and enhancing compensation with innovative options and expanded pay ranges based on experience, performance, education and demonstrated leadership.

It was felt that greater attention needed to be paid to the factors which promoted nurse satisfaction as the supply side of the workforce equation tightens. Several foundations have been

instrumental in stimulating innovative clinical 'restructuring' programmes, the most ambitious of which has been the Robert Wood Johnson Foundation/PEW Charitable Trust's 'Strengthening Hospital Nursing Program'. The aim of the programme is to redesign nursing services while improving patient care. Twenty hospitals have been awarded up to $1,000,000 each over five years to implement their proposals. Reconstructing the basis of professional practice has been one feature of the nationally acclaimed developments at Beth Israel Hospital, Boston, spearheaded by Joyce Clifford. These initiatives co-exist with other practice design models[77].

ACTION PLAN

Using inside and outside training, giving people feedback on development progress and instruction on how to manage their own development are elements which are already incorporated into programmes designed to develop nurse leaders. Examples include the learning sets for nurse managers and nursing development units sponsored by the King's Fund Centre, London. Fast track management programmes are also being undertaken by a number of health authorities to provide accelerated promotion for promising leaders. More attention needs to be paid to clinical leadership and the role of research in leadership development. Since leaders need to be 'grown' at all levels in the organisation, it takes a long time to develop them, and decades rather than years to create a culture of learning, to identify developmental jobs and a pool of talent.

It seems the leadership issue must be tackled on a number of fronts with multiple programmes threaded throughout the structure of the health service enabling leaders to be picked out and developed at all levels. But what should these programmes entail? A programme that might nurture a chief nursing officer may be totally unsuitable for producing a future trade union leader, and what may be appropriate for men may not apply to women. Local, rather than national programmes for leadership development, seem to make most sense (though secondments to the Department of Health, the NHS Management Executive and nursing organisations should be encouraged). There should be movement of people in and out of such organisations with good networks to support candidates, interviewees felt. A matrix of learning sets such as those initiated at the King's Fund College with one level feeding into another might be developed. Fast streaming has a lot to recommend it provided equal opportunities are upheld. Clinical leadership could be fostered by providing opportunities for ward sisters and charge nurses to develop the service through facilitative managerial support as suggested by the Audit Commission and confirmed by the research of Hart et al, Orton and Alsopp[78].

Nursing needs executive authority, but does it need nurse executives? Interviewees felt nurses need to become skilled in the politics of persuasion, networking, power-broking and designing health services around nursing 'need'. They need to take a greater leadership role in primary care, learn from other countries and engage with the socio-economic and global issues surrounding health care. Nursing requires leaders who are visionaries, people capable of considering all the options without feeling threatened.

Much more research is required into the identification and selection of leaders in nursing.

Nurses need to think laterally. Imagination is crucial in cases where there is no precedent or blueprint for action since it underpins innovations, risk-taking, invention exploring and adventuring. It is fundamental for achieving what has never been attempted or achieved before, for dealing with challenges for which there is no tradition or recipe for action.

Nursing needs people with vision, a sense of foresight and discernment in diagnosing the way forward. It also needs people who can inspire, move, energise and enthuse others. Development centres and demonstration units need to be established. A series of leadership seminars could be conducted, drawing upon available expertise within RCN and other Fellowship networks. Existing groups such as the Nurse Executive Network could be extended and new networks built producing a powerful domino effect. At present networks are very rudimentary and contain large gaps. Of vital importance is the provision of good support and supervision systems for leaders. Some kind of structure for development and challenge is critical. Arrangements, however, have to be organised and preferably structured around high quality personnel systems.

Mentoring at the formal and informal levels is to be encouraged during specific episodes of learning. But this needs to be defined. It was felt important to have people prepared to take would-be leaders under their wing and 'open doors'. This could be achieved through 'internship' and secondment programmes.

Fast tracking individuals with high potential for leadership roles in multi-disciplinary settings was also regarded as a key factor. Some felt that no allowance should be made for nurses in such programmes; that nurses should be expected to achieve the same level of credibility as others. Learning sets provided an action-learning programme to help leaders bring about change, gain and share some experience in organisational problem-solving[79].

Opportunities for leadership, it was felt, could be taken from any area provided nurses were not demoralised. One of the key tasks for leaders was how to provide practitioners who were flexible, highly educated, well paid and with high morale. Equal opportunities policies should ensure adequate representation of minority groups. What was needed was people who made life uncomfortable, who questioned the power groups like politicians and doctors and who utilised research. Interviewees felt nursing needed to attract the best brains, people who were articulate and published and who were comfortable with their own ambition. Getting it 'right' was less important than being prepared to take risks and make a start. It was felt that different kinds of leadership were needed at different levels and times and therefore it was vital to have a pool of leaders upon which to draw. For this to happen, a number of different models of leadership needed to be fostered.

CONCLUSION

Leadership in British nursing has been neglected by nurses and policy-makers. The legacy of this neglect is now being felt as nurses struggle to establish an identity and role for themselves in the changing environment of the NHS. Attempts to promote nursing leadership are not without their problems. There is the ambivalence attached to 'women's work' and the need to create a niche for nursing expertise in a division of labour over which nurses have only ever exerted minor influence. The historical divisions within nursing mean that different groups are likely to perceive the need for, and respond to, leadership in different ways. Add to this the diffidence nurses have met with when attempting to claim legitimacy in the leadership stakes, and a picture of confusing complexity emerges.

It is precisely this confusion, contradiction and complexity with which leaders have to contend. Changes on the scale which are currently affecting the health service create threats as well as opportunities. Are nurses going to be led by or initiate some of those changes?

There may be a number of reasons why nurses should be more optimistic than pessimistic. Firstly, their ability to meet the challenge of the ever-changing NHS is embedded within the very nature of clinical work: nurses already have considerable experience in coping with unstable environments. Secondly, interpersonal skills are often vaunted as the forte of nurses, to the extent that they can be said to constitute the literal 'heart' of nursing expertise. Nurses are no strangers to the power politics which surround practice either. Negotiating the political dimensions and boundaries of care has long been a feature of nursing work as the histories of nursing testify. Nurses have demonstrated their ability to innovate and extend the boundaries of their role and responsibilities. This has not always been welcomed by groups such as doctors, as the experiments with nursing beds in Oxford have demonstrated. Strong and effective nursing leadership is likely to threaten the leadership of other groups. Nurses must be prepared to tackle the conflict and confrontation this engenders. Moreover, they need to address the paradoxes which currently surround the NHS; the contradictory trends such as the tendency towards delegation of some functions with centralisation of others; flexibility and freedom within constraint; and professionalism in a climate hostile to traditional forms of professional privilege.

Intellectually, nurses have been historically disadvantaged. Like many other predominantly female occupations, nurses have largely been excluded from the educational institutions and resources which distribute the prestigious social and economic rewards in our society. What access to the elite institutions offers is not only access to privileged forms of knowledge, but knowledge of the way in which privilege operates, the networks and connections through which influence flows.

The hurdles detailed above are not easily overcome and discord needs to be healthy. The challenge is to turn 'difference' into strength. Nursing needs its sceptics, pragmatists and idealists. Each embraces a different view of change, and can be perceived in terms of a biological analogy. The sceptics believe in maintaining a 'critical' distance from the 'host' and exerting influence from outside. Pragmatists seek access to the 'host' by assuming its guise, influencing the organisation's structure from within. Theirs is a 'viral' philosophy of change. Idealists are the molecular biologists, radically reconstructing the organism by means of research and management techniques. Each constituency has something useful to offer and reflects the spectrum of opinion and reaction to the 'brave new world' of health care.

Verve and vision are needed in individuals willing to take the risk and responsibility for constructing a creative system of health care which expresses the values of nurses, and the value of nursing. Nurse leaders need not only the imagination but the political, practical and intellectual skills to take nursing forward. They must seize the initiative and promote a radical agenda to ensure that the key positions in nursing are filled by people with the calibre that the health service and the profession so urgently needs.

PARTICIPANTS IN THE INTERVIEW STUDY

Mr. Colin Ralph, Registrar and Chief Executive, United Kingdom Central Council.

Ms Christine Hancock, General Secretary, Royal College of Nursing.

Mr. Stephen Wright, Nurse Consultant, Nursing Development Unit, Tameside General Hospital.

Professor Jennifer Wilson-Barnett, King's College.

Mr. Ray Rowden, General Manager, Tooting Bec Hospital.

Dr. Alison Kitson, Royal College of Nursing Standards of Care Director, Instititute of Nursing, Oxford.

Professor June Clark, Middlesex Polytechic, President of the Royal College of Nursing.

Miss Pam Hibbs, Chief Nursing Officer, City and Hackney Health Authority, London.

Mr. Eric Caines, Director of Personnel, NHS Management Executive, Department of Health.

Professor Maureen Lahiff, Hatfield Polytechnic.

Alison Binnie, Senior Sister, John Radcliffe Hospital, Oxford.

Dr. Sue Pembrey, District Clinical Practice Development Nurse Director, Institute of Nursing, Oxford.

Mr. Duncan Nicol, NHS Management Executive, Department of Health.

Ms Julia Vaughan-Smith, National Health Service Training Authority.

Shirley Goodwin, King's Fund Institute.

Dr. Alison Terney, Nursing Research Unit, University of Edinburgh.

Mrs Yvonne Moores, Chief Nursing Officer, Scotland.

Mrs Ann Poole, Chief Nursing Officer, Department of Health.

Professor Margaret Green, Visiting Professor, Polytechnic of Central London and University of Exeter.

Sarah Whitfield, Chief Nurse Adviser, Bloomsbury and Islington Health Authority.

Professor Jane Robinson, Department of Nursing Studies, University of Nottingham.

Catherine McLoughlin, Director of Nursing for the NHS, Department of Health.

Dr. Trevor Clay, former General Secretary, Royal College of Nursing, and Vice-President, International Council of Nurses, Geneva.

Judith Bryant, King's Fund College.

Sheila Roy, Regional Nursing Officer, North West Thames Regional Health Authority.

Professor Patricia Scott, Department of Health Visiting and Nursing, University of Ulster.

Rosemary Knight, Regional Nursing Officer and Deputy Chief Executive, Merseyside Health Authority.

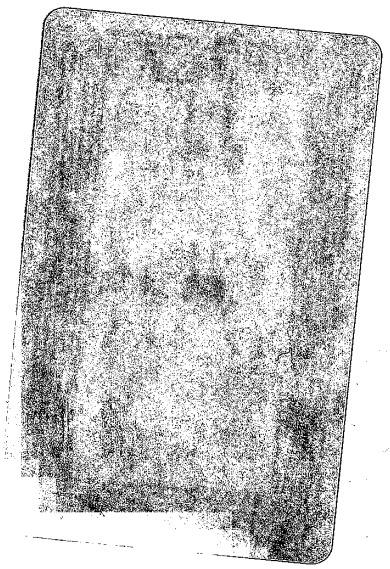
Jane Salvage, Director, Nursing Developments, King's Fund Centre.

REFERENCES

1. Stewart R, *Leading in the NHS; A Practical Guide.* (Macmillan, London 1989)
Schein E, *Organizational Culture and Leadership.* (Jossey Bass, San Francisco 1989)
2. Day P and Klein R, The Politics of Modernisation: Britain's National Health Service in the 1980s (*The Millbank Quarterly* 67 1 1-34)
3. Ministry of Health, Report of the Committee of Enquiry into the Cost of the National Health Service. (HMSO, London, 1959)
4. Webster C, *Problems of Health Care: The National Health Service before 1957.* (HMSO, London 1988)
5. Department of Health and Social Security, *NHS Management Inquiry.* (HMSO, London, 1983)
6. Strong P and Robinson J, *The NHS Under New Management.* (Open University Press, Milton Keynes, 1990)
7. *Ibid*, p26
8. International Council of Nurses, Preparation of Nurse Managers and Nurses in General Health Management. (Geneva, 1990)
9. Krantz J, and Gilmore TN, 'The Splitting of Leadership and Management as a Social Defence', *Human Relations*, 43 (2),188
10. Adair J, *Developing Leaders: The Ten Key Principles.* (Talbot Adair Press, Guildford, 1988) p13
11. Hunt J, *Leadership: A New Synthesis.* (Sage, London, 1991)
12. Schriesheim CA and Neider L, 'Leadership Theory and Development: The Coming 'New Phase', *Leadership and Organisational Development Journal*, (1989) 10.6, 17-26
13.Stogdill RM, 'Personal Factors Associated with Leadership: A Survey of the Literature' *Journal of Psychology* 25, 35-71
14. Hardy LK , 'Career Politics: The Case of Career Histories of Selected Leading Female and Male Nurses in England and Scotland' (R White, ed), *Political Issues in Nursing: Past, Present and Future vol.2* (John Wiley, London, 1986) p69–82
15. Davies C, and Rosser J, *Processes of Discrimination: A Study of Women Working in the NHS* (DHSS, London, 1986)
16. Dingwall R, 'Nursing: Towards a Male-Dominated Profession?' *Nursing Times*, 12 October (1972) , 68, 41, 1294-5)
17. Davies and Rosser, *op cit*, p60
18. Baxter C, *The Black Nurse: An Endangered Species?* (National Extension College, Cambridge, 1987)
Hicks C, 'Racism in Nursing', *Nursing Times* 12 May (1982)78, 18 789-91
Pearson M, 'Racism: The Great Divide', *Nursing Times*, 17 June (1987) 83 24, 27-8
Torkington P, 'Sorry, Wrong Colour,' *Nursing Times*, 17 June (1987) 83, 24, 27-28
Robinson K, The Nursing Workforce: Aspects of Inequality in Robinson, J; Gray, AM; and Elkan, R (eds), Policy Issues in Nursing (Open University Press, Milton Keynes, 1992) p24-37
19. King Edward's Hospital Fund for London, Equal Opportunities Task Force, Occasional Paper No 6. Racial Equality: The Nursing Profession (London 1988)
20 Equal Opportunities Commission, '*Equality Managment: Women's Employment in the NHS, A Survey Report*' (EOC, London 1991)
21. Carlisle D, 'On a Fast Track to the Top', *Nursing Times*, 2 January 1991, 25-6
22. National Health Service Management Executive, Women in the NHS: An Implementation Guide to Opportunity 2000 (NHSME, London, 1992) p3
23. *Ibid* p12

24. *Ibid* p7
25. *Ibid*
26. *Ibid* p8
27. Lewis J, *Women in Britain Since 1945.* (Blackwell, Oxford, 1992)
28. *Ibid* p120
29. Project 2000. The Final Proposals Project Paper 9 (UKCC, London, 1987)
30. Adair J, *Great Leaders* (Talbot Adair, Guildford Press, 1989) p19
31. *Ibid* p28
32. *Ibid* p33
33. *Ibid* p37
34. *Ibid* p38
35. *Ibid* p122
36. Hardy LK 'An Exploration of the Career Histories of Leading Female Nurses in England and Scotland' (University of Edinburgh, Ph.d., 1983
37. Jeruchim J and Shapiro P, *Women, Mentors and Success* (Fawcett Columbine, New York,1992) p23
38. *Ibid* p24
39. *Ibid* p29
40. *Ibid* p27
41. *Ibid* p29
42. *Ibid* p178-89
43. Davies and Rosser, *op cit*, p 59
44. Van Velsor E and Hughes M, Gender Differences in the Development of Managers: How Women Learn from Experience (Center for Creative Leadership, Greensboro, 1990) p1
45. *Ibid*
46. McCall M, Lombardo M and Morrison A, The Lessons of Experience: How Successful Executives Develop on the Job (Lexington Books, Mass, 1988)
47. Kotter J, The General Managers (Free Press, New York, 1982)
48. *Ibid* p5
49. McCall et al p12
50. *Ibid* p2
51. *Ibid*
52. *Ibid* p12
53 *Ibid* p13
54. Department of Health Nursing Division, *A Strategy for Nursing* (HMSO, London, 1989) p27-28
Lahiff M, 'Nurse Leadership in the UK' (unpublished position paper 1988)
55. Middlehurst R, Leadership Development in Universities 1986-1988: Final Report to the Department of Education and Science (University of Surrey, 1989)
56. Adair J, *Developing Leaders: Ten Key Principles* (Talbot Adair Press, Guildford, 1988)
57. Middlehurst R, 'Personal Communication: Informal Directory of Leadership Training Organisations', (London, 1991)
58. *Ibid*
59. *Ibid*
60. *Ibid*
61. *Ibid* p19-20
62. Chodorow N, 'Family Structure and Feminine Personality' in Rosaldo MZ aand Lamhere L (eds), *Women, Culture and Society* (Stanford University Press 1974); Gilligan C, *In a Different Voice: Psychological Theory and Women's Development*, (Harvard University Press, Cambridge, 1982)

63. Morrison A, White R, Van Velsor E, *Breaking the Glass Ceiling: Can Women ever Reach the Top of America's Largest Corporations?* (Centre for Creative Leadership, Greensboro, 1987)
64. McCall *et al op cit*
65. Van Velsor and Hughes, *op cit*, p37
66. *Ibid* p37
67. Van Velsor and Hughes, *op cit,* p 32
68. Horgan DD, 'A Cognitive Learning Perspective on Women Becoming Expert Managers', *Journal of Business and Psychology*, 3 (3), 299-313
69. Morrison, White and and Van Velsor, *op cit*
70. Western Network for Education in Health Administration, The 1992 Western Network Institute for Nurse Executives, (California, 1992); Wharton School University of Pennsylvania, 'Johnson and Johnson – Wharton Fellows Program in Management for Nurses,' (Philadelphia, 1992)
71. The Commonwealth Fund, Executive Nurse Fellowship Program (New York 1991)
72. M Fralic 'Patterns of Preparation: The Nurses Executive' Journal of Nursing Administration (1987), 17, 35-8
73. Scalzi C and Anderson R, 'Dual Degree: Future Preparation for Nurse Executives?' *Journal of Nursing Administration* 19, (1989), 25-28
74. *Ibid* p28
75. Scalzi C and Wilson D, 'Empirically Based Recommendations for Content of Graduate Nursing Administration Programs' *Nursing and Health Care*, 11, 522-5
76. *Ibid* p28
77. Wharton School University of Pennsylvania, *op cit*
78. Department of Health and Human Sciences, Secretary's Commission on Nursing: Interim Report, (Washington DC, 1988)
79. Clifford J and Horvath K (eds) *Advancing Professional Nursing Practice: Innovations at Beth Israel Hospital* (Springer, New York 1991)
Tonges MC, 'Redesigning Hospital Nursing Practice: The Professionally Advanced Care Team Model', *Journal of Nursing Administration,* 19 (7), July August 1989
Hartford Hospital, *Nursing News*, 14, 4 December 1990 p1
Bocchino C 'An Interview with Steven Schroeder,' *Nursing Economics* (1991)19 (6) 385-390
80. Audit Commission, *The Virtue of Patients making Best Use of of Ward Nursing Resources*, (HMSO, London, 1991) p50-3; Hart E, Robinson J, East L and Hillman R, Change in Process: Bringing About Change in Healthcare through Action Research, (Department of Nursing and Midwifery Studies, University of Nottingham, 1992); Orton H and Allsop D, 'We Have a Lot to Give'. A Report of the Sister/Charge Nurse Development Project September 1987-89 (Sheffield City Polytechnic, 1990)
81. Bryant J, 'Developing Learning Sets for Nurse Leaders', (unpublished paper, King's Fund College, 1990)




020000 048572

LEADING QUESTIONS

A discussion paper on the issues of Nurse Leadership

Anne Marie Rafferty

Is the nursing profession producing high calibre nurse leaders in sufficient numbers? And if not, why not, and what can be done to develop the nurse leaders of tomorrow? Anne Marie Rafferty clarifies the key issues of nurse leadership. She examines the nature of leadership – is the ability innate or can it be learned? – and goes on to explore the role of the nurse leader in the health service of tomorrow.

She enlists the help of a number of prominent figures in the nursing world to discover what attributes they believe are important and explores some of the barriers, racism and sexism for example, to nurses being able to develop leadership skills. There are also lessons to be learnt from the US experience.

Finally, Anne Marie Rafferty offers an action plan aimed at planners, managers and nurses alike.

9 781857 170405

£6.50

ISBN 1 85717 040 7